FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032813

Facility Name: SHARON HEALTH CARE WOODS, INC.

Address: 3301 W. RICHWOODS BLVD (Number) PEORIA (City) 61604 (Zip Code)

County: PEORIA

Telephone Number: (309) 685-5241 **Fax #** (309) 688-5746

IDPA ID Number: 36-3530582

Date of Initial License for Current Owners: 8/15/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD SGARLATA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	152	Intermediate (ICF)	152	55,632	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,632	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	53,506	550	122	54,178	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,506	550	122	54,178	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.39%

D. How many bed-hold days during this year were paid by Public Aid?
706 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	191,653	26,331	9,064	227,048		227,048		227,048			1
2	Food Purchase		237,562		237,562		237,562	(24)	237,538			2
3	Housekeeping	176,393	46,881		223,274		223,274		223,274			3
4	Laundry	58,500	27,754		86,254		86,254		86,254			4
5	Heat and Other Utilities			119,719	119,719		119,719	1,365	121,084			5
6	Maintenance	160,760	308	61,773	222,841		222,841	13,179	236,020			6
7	Other (specify):*											7
8	**TOTAL General Services**	587,306	338,836	190,556	1,116,698		1,116,698	14,520	1,131,218			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	831,834	18,365	152,455	1,002,654		1,002,654		1,002,654			10
10a	Therapy			1,350	1,350		1,350		1,350			10a
11	Activities	74,737	13,378	2,670	90,785		90,785		90,785			11
12	Social Services	157,276		18,530	175,806		175,806		175,806			12
13	Nurse Aide Training	1,644	1,954	416	4,014		4,014		4,014			13
14	Program Transportation			3,370	3,370		3,370		3,370			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,065,491	33,697	191,991	1,291,179		1,291,179		1,291,179			16
	C. General Administration											
17	Administrative	221,304		225,105	446,409		446,409	(88,095)	358,314			17
18	Directors Fees											18
19	Professional Services			27,429	27,429		27,429	(11,111)	16,318			19
20	Dues, Fees, Subscriptions & Promotions			18,522	18,522		18,522	(4,249)	14,273			20
21	Clerical & General Office Expenses	156,251	22,008	34,032	212,291		212,291	(21,287)	191,004			21
22	Employee Benefits & Payroll Taxes			295,899	295,899		295,899	(5,184)	290,715			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,146	2,146		2,146		2,146			24
25	Other Admin. Staff Transportation			1,771	1,771		1,771		1,771			25
26	Insurance-Prop.Liab.Malpractice			54,023	54,023		54,023	86	54,109			26
27	Other (specify):*							6,951	6,951			27
28	**TOTAL General Administration**	377,555	22,008	658,927	1,058,490		1,058,490	(122,889)	935,601			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,030,352	394,541	1,041,474	3,466,367		3,466,367	(108,369)	3,357,998			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SHARON HEALTH CARE WOODS, INC.
0032813
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #		
22	EMPLOYEE BENEFITS	_____
2	FOOD	_____

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	_____
19	PROFESSIONAL FEES	_____

To reclass cost of appealing real estate taxes

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. #0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			37,141	37,141		37,141	124,363	161,504			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							111,683	111,683			32
33	Real Estate Taxes			56,064	56,064		56,064	5,985	62,049			33
34	Rent-Facility & Grounds			591,820	591,820		591,820	(579,627)	12,193			34
35	Rent-Equipment & Vehicles			10,517	10,517		10,517		10,517			35
36	Other (specify):*							(28,656)	(28,656)			36
37	**TOTAL Ownership**			695,542	695,542		695,542	(366,252)	329,290			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,448	83,448		83,448		83,448			42
43	Other (specify):*							(22,454)	(22,454)			43
44	**TOTAL Special Cost Centers**			83,448	83,448		83,448	(22,454)	60,994			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,030,352	394,541	1,820,464	4,245,357		4,245,357	(497,075)	3,748,282			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,541	30		9
10	Interest and Other Investment Income	(27,126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,734)	22		19
20	Contributions	(3,148)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,048)	21		24
25	Fund Raising, Advertising and Promotional	(879)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,070)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(23,585)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (48,073)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(449,002)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (449,002)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (497,075)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHARON HEALTH CARE WOODS, INC.

ID# 0032813

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 13,154	6	1
2	NON-ALLOWABLE SALARY	(22,454)	43	2
3	RESIDENT GIFTS	(450)	22	3
4	RISK MANAGEMENT FEES	(12,000)	19	4
5	COPE DUES - ICLTC	(228)	20	5
6	MISCELLANEOUS INCOME	(60)	21	6
7	PAINTING AND DECORATING	(1,547)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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20				20
21				21
22				22
23				23
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29				29
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80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(23,585)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(24)											(24)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities						1,365						1,365	5
6	Maintenance	11,607					1,572						13,179	6
7	Other (specify):*													7
8	**TOTAL General Services**	11,583					2,937						14,520	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				(88,095)								(88,095)	17
18	Directors Fees													18
19	Professional Services	(12,000)		283	174	432							(11,111)	19
20	Fees, Subscriptions & Promotions	(4,255)					6						(4,249)	20
21	Clerical & General Office Expenses	(20,178)					(1,109)						(21,287)	21
22	Employee Benefits & Payroll Taxes	(5,184)											(5,184)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice						86						86	26
27	Other (specify):*				4,984		1,967						6,951	27
28	**TOTAL General Administration**	(41,617)		283	(82,937)	432	950						(122,889)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,034)		283	(82,937)	432	3,887						(108,369)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	31,541		91,861		961							124,363	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(27,126)		138,803		6							111,683	32
33	Real Estate Taxes			(853)		2,629	4,209						5,985	33
34	Rent-Facility & Grounds			(561,320)		(2,000)	(16,307)						(579,627)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*					(28,656)							(28,656)	36
37	**TOTAL Ownership**	4,415		(331,509)		(27,060)	(12,098)						(366,252)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(22,454)											(22,454)	43
44	**TOTAL Special Cost Centers**	(22,454)											(22,454)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(48,073)		(331,226)	(82,937)	(26,628)	(8,211)						(497,075)	45

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	PEORIA FOREST PARTNERSHIP	100.00%	$ 283	$ 283	15
16	V	30	DEPRECIATION		PEORIA FOREST PARTNERSHIP		91,861	91,861	16
17	V	32	INTEREST		PEORIA FOREST PARTNERSHIP		138,803	138,803	17
18	V	33	REAL ESTATE TAX		PEORIA FOREST PARTNERSHIP		(853)	(853)	18
19	V								19
20	V	34	RENT	561,320	PEORIA FOREST PARTNERSHIP			(561,320)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 561,320			$ 230,094	$ * (331,226)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	REDWOOD MANAGEMENT	100.00%	$ 174	$ 174	15
16	V								16
17	V	17	MANAGEMENT FEES	225,105	REDWOOD MANAGEMENT			(225,105)	17
18	V								18
19	V	17	SALARY-L.SHLOFROCK		REDWOOD MANAGEMENT		101,760	101,760	19
20	V	27	PAYROLL TAXES-LS		REDWOOD MANAGEMENT		2,273	2,273	20
21	V								21
22	V	17	SALARY-J.SHLOFROCK		REDWOOD MANAGEMENT		15,000	15,000	22
23	V	27	PAYROLL TAXES-JS		REDWOOD MANAGEMENT		1,154	1,154	23
24	V								24
25	V	17	SALARY-S. ARON		REDWOOD MANAGEMENT		15,000	15,000	25
26	V	27	PAYROLL TAXES-SA		REDWOOD MANAGEMENT		1,154	1,154	26
27	V								27
28	V	17	SALARY-J.MAGIT		REDWOOD MANAGEMENT		5,250	5,250	28
29	V	27	PAYROLL TAXES-JM		REDWOOD MANAGEMENT		404	404	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 225,105			$ 142,168	$ * (82,937)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	UNIT SIX PARTNERSHIP	100.00%	$ 432	$ 432	15
16	V	30	DEPRECIATION		UNIT SIX PARTNERSHIP		961	961	16
17	V	32	INTEREST		UNIT SIX PARTNERSHIP		6	6	17
18	V	33	REAL ESTATE TAX		UNIT SIX PARTNERSHIP		2,629	2,629	18
19	V	36	GAIN ON SALE OF ASSET		UNIT SIX PARTNERSHIP		(28,656)	(28,656)	19
20	V								20
21	V	34	RENT	2,000	UNIT SIX PARTNERSHIP			(2,000)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,000			$ (24,628)	$ * (26,628)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BARTON MANAGEMENT INC.	100.00%	$ 1,365	$ 1,365	15
16	V	6	REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,572	1,572	16
17	V	20	DUES, SUBS. & FEES		BARTON MANAGEMENT INC.		6	6	17
18	V	21	CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		(1,109)	(1,109)	18
19	V	26	INSURANCE		BARTON MANAGEMENT INC.		86	86	19
20	V	27	EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		1,967	1,967	20
21	V	33	REAL ESTATE TAXES		BARTON MANAGEMENT INC.		4,209	4,209	21
22	V	34	RENT OFFICE SPACE		BARTON MANAGEMENT INC.		12,193	12,193	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	28,500	BARTON MANAGEMENT INC.			(28,500)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,500			$ 20,289	$ * (8,211)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEON SHLOFROCK	SHAREHOLDER	Administrative	16.30%	SEE ATTACHED	4	8.00	Alloc.-RDWD	$ 101,760	17-7	1
2	JOHN SHLOFROCK	SHAREHOLDER	Administrative	11.02%	SEE ATTACHED	8	17.02	Alloc.-RDWD	15,000	17-7	2
3	JOE MAGIT	SHAREHOLDER	Administrative	8.00%	SEE ATTACHED	3	9.00	Alloc.-RDWD	5,250	17-7	3
4	STANTON ARON	SHAREHOLDER	Administrative	7.67%	SEE ATTACHED	3.5	5.38	Alloc.-RDWD	15,000	17-7	4
5	ELISA SHLOFROCK-ZUSM	SHAREHOLDER	Clerical	2.05%	SEE ATTACHED	5.5	13.75	SALARY	8,147	21-1	5
6	GARY WEINTRAUB	SHAREHOLDER	Legal	1.89%	SEE ATTACHED	5	12.50	SALARY	27,186	17-1	6
7	JEAN SHLOFROCK	RELATIVE	Clerical	0.00	SEE ATTACHED	4.5	11.25	SALARY	2,186	21-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 174,529		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PEORIA FOREST PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,100	$	152	$ 283	1
2	30	DEPRECIATION	BED SIZE	590	4	356,566		152	91,861	2
3	32	INTEREST	BED SIZE	590	4	538,773		152	138,803	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	(3,311)		152	(853)	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 893,128	$		$ 230,094	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: REDWOOD MANAGEMENT
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 675	$	152	$ 174	1
2										2
3										3
4										4
5	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	636,000	636,000	4	101,760	5
6	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	14,206		4	2,273	6
7										7
8	17	SALARY-J.SHLOFROCK	AVG HOURS WORKED	32	4	60,000	60,000	8	15,000	8
9	27	PAYROLL TAXES-JS	AVG HOURS WORKED	32	4	4,615		8	1,154	9
10										10
11	17	SALARY-S. ARON	AVG HOURS WORKED	14	4	60,000	60,000	4	15,000	11
12	27	PAYROLL TAXES-SA	AVG HOURS WORKED	14	4	4,615		4	1,154	12
13										13
14	17	SALARY-J.MAGIT	AVG HOURS WORKED	12	4	21,000	21,000	3	5,250	14
15	27	PAYROLL TAXES-JM	AVG HOURS WORKED	12	4	1,616		3	404	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 802,727	$ 777,000		$ 142,168	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: UNIT SIX PARTNERSHIP
Street Address: 465 CENTRAL AVE. ,SUITE 100
City / State / Zip Code: NORTHFIELD, IL. 60093
Phone Number: ((847) 441-8200
Fax Number: ((847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	BED SIZE	590	4	$ 1,675	$	152	$ 432	1
2	30	DEPRECIATION	BED SIZE	590	4	3,731		152	961	2
3	32	INTEREST	BED SIZE	590	4	22		152	6	3
4	33	REAL ESTATE TAX	BED SIZE	590	4	10,206		152	2,629	4
5	36	GAIN ON SALE OF ASSET	BED SIZE	590	4	(111,229)		152	(28,656)	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ (24,628)	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BARTON MANAGEMENT INC.
Street Address: 465 CENTRAL AVE.
City / State / Zip Code: NORTHFIELD, IL 60093
Phone Number: (847) 441-8200
Fax Number: (847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	199,800	8	$ 9,569	$	28,500	$ 1,365	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	199,800	8	11,020		28,500	1,572	2
3	20	DUES, SUBS. & FEES	RENTAL INCOME	199,800	8	40		28,500	6	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	199,800	8	(7,772)		28,500	(1,109)	4
5	26	INSURANCE	RENTAL INCOME	199,800	8	604		28,500	86	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	199,800	8	13,792		28,500	1,967	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	199,800	8	29,507		28,500	4,209	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	199,800	8	85,477		28,500	12,193	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 142,237	$		$ 20,289	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Supplemental Schedule										111,683	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 111,683	14
15	TOTALS (line 9+line14)						$	$			$ 111,683	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (21,581)	1
2	ALLOC-PEORIA FOREST	X									138,803	2
3	ALLOC-UNIT SIX	X									6	3
4	DIVDEND INCOME										(5,545)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 111,683	21

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	54,985	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,689	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,704	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	56,345	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	62,049	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,695	8
	1996	48,965	9
	1997	51,089	10
	1998	53,384	11
	1999	54,704	12

CALCULATION OF ACCRUAL = 54704 X 1.03 = 56345

ALLOCATED FROM PEORIA FOREST = (853)

ALLOCATED FROM BARTON MGMT = 4209

ALLOCTED FROM UNIT SIX = 2629

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SHARON HEALTHCARE WILLOWS - FACILITY - 219 BEDS
SHARON HEALTHCARE ELMS - FACILITY - 99 BEDS
SHARON HEALTHCARE PINES - FACILITY - 120 BEDS
PEORIA FOREST - CENTRAL DIETARY (FORMERLY UNIT SIX PARTNERSHIP)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 161,249	1
2	PEORIA FOREST			12,897	2
3	TOTALS			$ 174,146	3

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	152		1991		$ 2,864,500	$ 90,948	35	$ 90,948	$	$ 882,954	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	18,543	357	20	927	570	7,886	9
10	Various			1988	20,355	646	20	1,018	372	10,710	10
11	Various			1989	7,490	283	20	396	113	4,037	11
12	Various			1990	39,136	1,379	20	2,023	644	18,690	12
13	Various			1991	7,089	225	20	355	130	3,064	13
14	Various			1992	45,962	2,070	20	2,298	228	11,490	14
15	Various			1993	19,912	531	20	995	464	7,121	15
16	Various			1994	15,494	483	20	810	327	5,184	16
17	Various			1995	21,826	560	20	1,091	531	6,052	17
18	FLOORING			1996	3,266	84	20	163	79	693	18
19	BATHROOM FIXTURES			1996	518	13	20	26	13	119	19
20	CARPET			1996	543	14	20	27	13	112	20
21	VANITIES			1996	1,204	31	20	60	29	285	21
22	FLOORING			1996	2,627	67	20	131	64	611	22
23	VANITIES			1996	1,660	43	20	83	40	387	23
24											24
25	PAGE 12-1 REP TOTALS				60,542	1,874		913	(961)	913	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				1,379	16		35	19	35	32
33	PAGE 12C TOTALS				72,989	1,380		2,766	1,386	3,270	33
34	PAGE 12B TOTALS				51,596	1,323		2,582	1,259	4,603	34
35	PAGE 12A TOTALS				91,689	2,350		4,587	2,237	15,011	35
36	TOTAL (lines 4 thru 35)				$ 3,348,320	$ 104,677		$ 112,234	$ 7,557	$ 983,227	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VANITIES			1996	262	7	20	13	6	60	9
10	A/C COMPRESSOR			1996	1,474	38	20	74	36	327	10
11	VANITIES			1996	1,786	46	20	89	43	430	11
12	FLOORING			1996	2,577	66	20	129	63	613	12
13	BATHROOM FIXTURES			1996	782	20	20	39	19	185	13
14	CONCRETE			1996	5,534	142	20	277	135	1,177	14
15	WINDOWS			1996	948	24	20	47	23	215	15
16	DRAPERY			1997	11,466	294	20	573	279	2,149	16
17	PAVE DRIVEWAY			1997	8,347	214	20	417	203	1,390	17
18	TILE ROOMS			1997	731	19	20	37	18	117	18
19	DRAIN LINE REPAIR			1997	1,650	42	20	83	41	284	19
20	TILE BATHROOMS			1997	514	13	20	26	13	93	20
21	EXHAUST FAN			1997	3,460	89	20	173	84	620	21
22	WINDOWS			1997	1,357	35	20	68	33	238	22
23	VANITIES			1997	723	19	20	36	17	117	23
24	TILE STATION			1997	4,961	127	20	248	121	785	24
25	WATER HEATER			1997	2,390	61	20	120	59	370	25
26	NURSING STATION			1997	11,212	287	20	561	274	1,823	26
27	POWERS MIXING VALVES			1997	952	24	20	48	24	168	27
28	NURSE STATION			1997	609	16	20	30	14	95	28
29	FLOORING			1998	634	16	20	32	16	75	29
30	DOORS			1998	683	18	20	34	16	94	30
31	CONDENSOR			1998	1,331	34	20	67	33	179	31
32	ROOFTOP A/C			1998	2,031	52	20	102	50	255	32
33	WINDOW			1998	954	24	20	48	24	116	33
34	A/C COMPRESSOR			1998	1,175	30	20	59	29	143	34
35	DRIVEWAY & LOT			1998	23,146	593	20	1,157	564	2,893	35
36	TOTAL (lines 4 thru 35)				$ 91,689	$ 2,350		$ 4,587	$ 2,237	$ 15,011	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AMER II MINUTEMAN			1998	418	11	20	21	10	51	9
10	DOOR			1998	628	16	20	31	15	72	10
11	VANITY			1998	597	15	20	30	15	68	11
12	WIRING-FRONT LIGHT			1998	582	15	20	29	14	77	12
13	VANITY			1998	501	13	20	25	12	73	13
14	WINDOWS			1998	954	24	20	48	24	112	14
15	WATER HEATER			1998	2,270	58	20	114	56	247	15
16	ROOF TOP UNIT			1998	5,825	149	20	291	142	606	16
17	PHONE SHELF			1998	318	8	20	16	8	41	17
18	DRAIN			1998	518	13	20	26	13	74	18
19	WINDOWS			1998	1,364	35	20	68	33	187	19
20	CONDENSING UNIT			1999	1,987	51	20	99	48	149	20
21	PATIO			1999	4,815	123	20	241	118	301	21
22	GUTTERS/SPOUTS			1999	650	17	20	33	16	47	22
23	ELECTRICAL WIRING			1999	1,858	48	20	93	45	171	23
24	WINDOWS			1999	481	12	20	24	12	44	24
25	A/C COMPRESSOR			1999	1,313	34	20	66	32	105	25
26	GARAGE DOOR			1999	218	6	20	11	5	20	26
27	WINDOWS			1999	511	13	20	26	13	39	27
28	WINDOWS			1999	124	3	20	6	3	11	28
29	LOBBY DECORATIONS			1999	725	19	20	36	17	54	29
30	ROOFING			1999	860	22	20	43	21	65	30
31	VANITIES			1999	533	14	20	27	13	38	31
32	FREEZER CONDENSOR			1999	1,848	47	20	92	45	169	32
33	CUBICLE CURTAINS			1999	2,672	69	20	134	65	212	33
34	HEAT/COOL UNIT			1999	2,876	74	20	144	70	156	34
35	ROOF			1999	16,150	414	20	808	394	1,414	35
36	TOTAL (lines 4 thru 35)				$ 51,596	$ 1,323		$ 2,582	$ 1,259	$ 4,603	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			1999	7,850	201	20	393	192	557	9
10	WINDOWS (3)			1999	722	19	20	36	17	45	10
11	HEAT IGNITION SYSTEM			1999	754	19	20	38	19	41	11
12	CONCRETE PARKING LOT			1999	1,488	38	20	74	36	86	12
13	ROOF			1999	7,800	200	20	390	190	455	13
14	HEATERS			1999	1,362	35	20	68	33	136	14
15	DOWNSPOUT			1999	1,880	48	20	94	46	118	15
16	SLIDING DOORS			1999	3,200	82	20	160	78	200	16
17	CUBICLE CURTAINS			1999	2,612	67	20	131	64	164	17
18	FURNACE			1999	2,443	63	20	122	59	153	18
19	FENCE			1999	600	15	20	30	15	40	19
20	LAUNDRY SINK/TUB			1999	2,020	52	20	101	49	135	20
21	REBUILD ROOF FURNACE			1999	2,581	66	20	129	63	140	21
22	ROOF DUCTWORK			2000	1,668	41	20	83	42	83	22
23	NURSES STATION			2000	10,500	146	20	306	160	306	23
24	NURSES STATION(ADDL)			2000	866	3	20	7	4	7	24
25	VANITY CABINET (2)			2000	809	20	20	40	20	40	25
26	FURNACE			2000	1,158	26	20	53	27	53	26
27	VANITY CABINET (2)			2000	812	17	20	34	17	34	27
28	A/C UNIT			2000	968	18	20	36	18	36	28
29	A/C UNIT			2000	2,870	40	20	84	44	84	29
30	AWNING			2000	8,200	96	20	205	109	205	30
31	DOORS			2000	1,037	10	20	22	12	22	31
32	ROOFTOP UNIT			2000	6,368	48	20	106	58	106	32
33	WATER HEATER			2000	530	3	20	7	4	7	33
34	PARKING SPACES			2000	137	1	20	2	1	2	34
35	WINDOWS/SCREENS			2000	1,754	6	20	15	9	15	35
36	TOTAL (lines 4 thru 35)				$ 72,989	$ 1,380		$ 2,766	$ 1,386	$ 3,270	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DUCTWORK			2000	1,379	16	20	35	19	35	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,379	$ 16		$ 35	$ 19	$ 35	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1991	UNIT SIX	$	$ 961		$	$ (961)	$	4
5			1991	PEORIA FOR	60,542	913	31.5	913		913	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 60,542	$ 1,874		$ 913	$ (961)	$ 913	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 426,545	$ 15,711	$ 41,975	$ 26,264		$ 337,988	37
38	Current Year Purchases	32,494	4,703	1,820	(2,883)		1,820	38
39	Fully Depreciated Assets	92,867		603	603		92,867	39
40								40
41	TOTALS	$ 551,906	$ 20,414	$ 44,398	$ 23,984		$ 432,675	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	1997 DODGE RAM	1999	$ 12,821	$ 4,872	$ 4,872	$	5	$ 5,513	42
43										43
44										44
45										45
46	TOTALS			$ 12,821	$ 4,872	$ 4,872	$		$ 5,513	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,087,193	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 129,963	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 161,504	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 31,541	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,421,415	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SHARON HEALTH CARE WOODS, INC.
0032813
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
SHARON HEALTHCARE ELMS	139,478	15,711	13,268	(2,443)	61,223
PEORIA FOREST	285,864		28,587	28,587	276,344
UNIT SIX					
BARTON MANAGEMENT	1,203		120	120	421
TOTALS	426,545	15,711	41,975	26,264	337,988
LINE 29: CURRENT YEAR					
SHARON HEALTHCARE ELMS	32,494	4,703	1,820	(2,883)	1,820
PEORIA FOREST					
UNIT SIX					
BARTON MANAGEMENT					
TOTALS	32,494	4,703	1,820	(2,883)	1,820
LINE 30: FULLY DEPRECIATED					
SHARON HEALTHCARE ELMS	92,867		603	603	92,867
PEORIA FOREST					
UNIT SIX					
BARTON MANAGEMENT					
TOTALS	92,867		603	603	92,867
TOTALS (Should Tie to Totals on Page 13)					
SHARON HEALTHCARE ELMS	264,839	20,414	15,691	(4,723)	155,910
PEORIA FOREST	285,864		28,587	28,587	276,344
UNIT SIX					
BARTON MANAGEMENT	1,203		120	120	421
TOTALS	551,906	20,414	44,398	23,984	432,675

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC-BARTON				12,193			5
6								6
7	TOTAL				$ 12,193 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,344 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	VAN	$ 229.00	$ 4,117	17
18	FACILITY	TRUCK	N/A	56	18
19					19
20					20
21	TOTAL		$ 229.00	$ 4,173	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	540	1,413		1,953
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	455	1,189		1,644
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests	115	301		416
9	TOTALS	$ 1,110	$ 2,903	$	$ 4,013
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,013			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 8,003

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 239,617	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	559,263		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,354		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	1,263		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 816,497	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	429,535		15
16	Equipment, at Historical Cost	264,098		16
17	Accumulated Depreciation (book methods)	(280,242)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 413,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,229,888	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,776	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,695		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,671		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,345		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 213,487	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 213,487	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,016,401	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,229,888	$	48

***(See instructions.)**

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. **#** 0032813 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
INTEREST RECEIVABLE	1,035	
SECURITY DEPOSIT	228	
	1,263	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,899,189	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,899,189	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	139,882	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,022,670)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (882,788)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,016,401	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	SHARON HEALTH CARE WOODS, I #	0032813	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,899,189
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,899,189
Equity(Deficit) from Page 17 Col 1		1,016,401
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,016,401

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,347,785	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,347,785	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,003	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 8,003	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,126	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,126	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,325	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,325	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,385,239	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,116,698	31
32	Health Care	1,291,179	32
33	General Administration	1,058,490	33
	B. Capital Expense		
34	Ownership	695,542	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	83,448	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,245,357	40
41	**Income before Income Taxes (line 30 minus line 40)****	139,882	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 139,882	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHARON HEALTH CARE WOODS # 0032813 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	MISCELLANEOUS INCOME (ADJ. OFF PAGE 5)	60
2	VENDING COMMISSIONS	2,176
3	PHONE COMMISSIONS	89
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	2,325

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 46,998	$ 22.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,726	18,832	325,225	17.27	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	39,634	44,586	355,072	7.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,626	10,045	83,648	8.33	8
9	Activity Director					9
10	Activity Assistants	8,991	9,481	74,737	7.88	10
11	Social Service Workers	11,644	12,532	157,276	12.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,345	22,879	191,653	8.38	15
16	Dishwashers					16
17	Maintenance Workers	18,281	18,966	160,760	8.48	17
18	Housekeepers	20,501	22,050	176,393	8.00	18
19	Laundry	2,314	2,330	58,500	25.11	19
20	Administrator	2,080	2,080	75,680	36.38	20
21	Assistant Administrator	2,080	2,080	48,253	23.20	21
22	Other Administrative	2,356	2,459	97,371	39.60	22
23	Office Manager					23
24	Clerical	14,193	15,091	156,251	10.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,978	2,121	20,891	9.85	31
32	Other Health Care(specify)					32
33	Other(specify)	149	159	1,644	10.34	33
34	TOTAL (lines 1 - 33)	174,978	187,771	$ 2,030,352 *	$ 10.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	239	$ 9,064	1-3	35
36	Medical Director	130	13,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	92	1,560	10-3	39
40	Physical Therapy Consultant	14	638	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	16	712	10A-3	43
44	Activity Consultant	76	2,670	11-3	44
45	Social Service Consultant	36	1,260	12-3	45
46	Other(specify) PSYCHIATRIC	69	5,170	12-3	46
47	PSYCHO-SOCIAL	346	12,100	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,018	$ 46,374		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	686	$ 22,634	10-3	50
51	Licensed Practical Nurses	536	15,090	10-3	51
52	Nurse Aides	7,163	113,172	10-3	52
53	TOTAL (lines 50 - 52)	8,385	$ 150,896		53

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
CNA TRAINER WAGES	149	159	$ 1,644	$ 10.34
	149	159	$ 1,644	$ 10.34

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BOBBY FORD	ADMINISTRATOR	0.00	$ 75,680
DENISE CHAPPE	ASST. ADMIN	0.00	48,253
GARY WEINTRAUB	LEGAL	1.89%	27,186
RICK DURROS	FINANCIAL OFF	0.00	31,748
JOHN SHLOFROCK	ADMINISTRATIVE	11.02%	12,121
PATRICIA SHERIDAN	ADMINISTRATIVE		26,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 221,304

B. Administrative - Other

Description	Amount
REDWOOD - MANAGEMENT FEES	$ 225,105
TOTAL (agree to Schedule V, line 17, col. 3)	$ 225,105
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALLOC-BARTON	ACCOUNTING	$ 410
FR&R	ACCOUNTING	7,150
ALPHA DATA SERVICES	COMPUTER	3,307
CENTRAL PLAZA-THRESHOLD	COMPUTER	1,904
COMPUTER AGE	COMPUTER	169
MEDE AMERICA	COMPUTER	120
	* Risk Mgmt. Fees	12,000
Q-QUEST SERVICES	COMPUTER	189
MID AMERICAN PROGRAM	COMPUTER	1,320
ALLOC-BARTON	COMPUTER	558
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	980
* Adjusted out on page 5.		(677)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,430

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,425
Unemployment Compensation Insurance	17,341
FICA Taxes	148,542
Employee Health Insurance	53,844
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CHRISTMAS EXPENSE	5,273
EMPLOYEE BENEFITS	2,207
401K CONTRIBUTION	1,084
TOTAL (agree to Schedule V, line 22, col.8)	$ 290,716

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	7,677
Health Care Worker Background Check	723
(Indicate # of checks performed 73)	
DUES, SUBSCRIPTIONS	333
ALLOC-BARTON	116
LICENSES AND FEES	388
DUES - ICLTC	4,636
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,273

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,146
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,146

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHARON HEALTH CARE WOODS, INC. # 0032813 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING & DECO	1994	$ 2,808	3	$ 468	$	$	$	$	$	$	$	$
2	PAINTING & DECO	1995	7,923	3	2,641								
3	PAINTING & DECO	1996	1,598	3	533	532							
4	PAINTING & DECO	1997	2,174	3	724	725	725						
5	PAINTING & DECO	1998	37,066	3		6,178	12,355	12,355	6,178				
6	PAINTING & DECO	1999	1,627	3			271	542	542	272			
7	PAINTING & DECO	2000	1,547	3				257	516	516	258		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 54,743		$ 4,366	$ 7,435	$ 13,351	$ 13,154	$ 7,236	$ 788	$ 258	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - 4636**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **83,448**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NO**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of In**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw